Texas CHAP Consumer Health Assistance Program

Texas Department of Insurance
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www.TexasHealthOptions.com

Fact Sheet

Provisions of Federal Health Care Reform

The Patient Protection and Affordable Care Act (the federal health care reform law) gives Texans new rights and protections.

Choice in Doctors
The law allows you a choice when seeking health care.

- **You select the doctor.** The law allows you to choose any available participating doctor to be your primary care provider. You also can choose any available participating pediatrician to be your child's primary care doctor.
- **No barriers to OB-GYN services.** The law prohibits insurance companies from requiring you to get a referral before seeing a participating OB-GYN specialist.
- **Access to out-of-network emergency room services.** The law prevents companies from charging higher copayments or coinsurance for emergency room services that you get outside your plan's network for a medical emergency. The law also prohibits plans from requiring you to get prior approval before getting emergency care from a doctor or hospital outside of your plan's network.

However, you might have to pay the difference between the amount a provider bills for out-of-network emergency room services and the amount your company pays.

Losing Your Insurance
Group and individual plans can no longer rescind coverage if you get sick or make an honest mistake on your application. (*Rescind* means to cancel a policy back to its effective date. In effect, it's as if the policy had never been issued.)

Companies may only rescind a policy if you commit fraud or intentionally misrepresent a material fact.

If your company determines that you intentionally put false or incomplete information on your insurance application, it must give you at least 30 calendar days' notice before rescinding your coverage. During that time, you may be able to appeal the decision or find new coverage.

Getting Value for Your Premium
The law limits how much of your premium companies can spend on administrative costs, marketing, and other non-health care-related costs.

Companies must spend at least 80 percent (85 percent for large employer plans) of your premium on direct medical care and improving your quality of care. This is called the medical loss ratio.

Companies that don't spend at least 80 percent of premium dollars collected on direct medical care must give their plan participants a rebate. The rebate may go to the employer if the employer paid employees' premiums.

The law requires your insurance company to justify unreasonable premium increases to the Texas Department of Insurance and the U.S. Department of Health and Human Services. You can view your company's medical loss ratio at http://companyprofiles.healthcare.gov/.

Free Preventive Services
If you have insurance, you can now get some preventive services free.

You don't have to pay a copayment or coinsurance or meet a deductible requirement. Your health plan may require you to go to a network provider for free preventive services.

Depending on your age, you might have free access to preventive services such as:

- blood pressure, diabetes, and cholesterol tests
- mammograms and colonoscopies
- smoking cessation, weight loss, and alcohol use counseling
- flu and pneumonia shots
- well-baby and well-child visits until age 21.

For lists of preventive services, visit http://www.healthcare.gov/prevention.

If you don't see a network provider and your plan requires it, you may still be charged for the service. You will also be charged a copay for services that don't qualify as preventive services.

This provision applies to employment-based group health plans and individual health insurance policies that are not "grandfathered."

Lifetime and Annual Limits
The health care reform law prohibits companies from putting a lifetime dollar limit on essential health benefits and restricts the annual dollar limits a company can place on essential health benefits. Plans may replace these dollar limits with limits on the number of office visits or days in a facility that the plan will cover.

The ban on lifetime dollar limits applies to all individual and employment-based group health plans.

The phase-out of annual dollar limits applies to all employment-based group health plans and individual health insurance policies issued after March 23, 2010.

The phase-out means plans can't set annual dollar limits lower than:

- $1.25 million for a plan year or policy year between September 23, 2011, and September 23, 2012.
- $2 million for a plan year or policy year between September 23, 2012, and January 1, 2014.

Note: A plan year is a 12-month period of benefits coverage, which may not be the same as the calendar year. This period is called a policy year for individual policies.

Plans must eliminate annual dollar limits on most benefits beginning January 1, 2014.

The lifetime and annual caps only apply to "essential health benefits." Essential health benefits are items and services – such as emergency services, hospitalization, and prescription drugs – that plans must offer.

Your plan or policy can still put dollar limits on health benefits that aren't considered essential health benefits. Some plans or policies may get a waiver from the annual dollar limit rule if complying would mean a large decrease in your coverage or large increase in your premiums. Plans granted waivers are listed at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

Grandfathered Plans
Grandfathered health plans are individual and group plans that existed on March 23, 2010, when Congress passed the health care reform law.

Grandfathered plans are exempt from some of the health care reform law's provisions. However, some of the provisions may still be available under Texas law.

Except as required by state law, grandfathered plans are not required to

- provide preventive services with no charge or copayment.
- offer new protections for consumers who are appealing claims and coverage denials.
- allow choice of providers.
- provide expanded access to emergency care.

Grandfathered individual health plans are not required to

- phase out annual dollar limits on essential benefits.
- eliminate preexisting condition exclusions for children under 19.

(These protections do apply to grandfathered *group* health plans.)

Your health plan can lose its grandfathered status if

- it stops offering all or most benefits to diagnose or treat specified conditions, such as, diabetes, cystic fibrosis, or HIV/AIDS.
- it significantly increases the deductible, out-of-pocket maximum, or any cost-sharing.
- it significantly increases your copayment (the fee that you must pay for a covered health service).
- it imposes a new annual limit on the dollar value of all benefits or lowers an existing annual limit.
- your employer decreases its share of your premium by more than five percentage points (for example, from 20 percent to 15 percent.)

Note: Your health plan may increase your premiums and still be grandfathered, as long as it doesn't make any of the changes listed above.

Additional Assistance
For more information, contact the U.S. Department of Labor about employment-based group health plans and the U.S. Department of Health and Human Services about individual health insurance policies.